THIS DECISION HAS BEEN APPEALED. THE FOLLOWING IS THE RELATED SOAH DECISION NUMBER:

SOAH DOCKET NO. 453-05-3286.M4

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Dr. S 431 Omega Drive, Suite 104 Arlington, Texas 76014	MDR Tracking No.: M4-03-5444-01 TWCC No.: ____ Injured Employee's Name: ____
Respondent's Name and Address State Office of Risk Management Box 45	Date of Injury: ____ Employer's Name: ____ Insurance Carrier's No.: 1874460

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
09/27/02	09/27/02	99214	$23.00	$0.00
12/20/02	12/20/02	99214	$71.00	$71.00

PART III: REQUESTOR'S POSITION SUMMARY

Provider indicates insurance carrier reimbursed at another billing codes value stating that documentation does not support the level billed.

PART IV: RESPONDENT'S POSITION SUMMARY

Respondent's position statement indicates additional reimbursement was made for date of service 09/27/02 in the amount of $23.00 plus interest. The date of service 12/20/02 was denied for insufficient documentation to support the level of office visit billed.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per the carrier's position statement, the date of service 09/27/02 was reimbursed in the amount of $23.00 plus interest and is no longer in dispute. The date of service 12/22/02 was not reimbursed and was denied for insufficient documentation. Upon reviewing the documentation submitted by the requestor, documentation for the date of service 12/20/02 supports the level of office visit billed per the Medical Fee Guideline. Accordingly, reimbursement is recommended for the date of service 12/20/02.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $71.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Michael Bucklin	12/13/04
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____